



**Nuclear Medicine History Sheet**

Acct # \_\_\_\_\_ Date \_\_\_\_\_

Patient's Name \_\_\_\_\_

Exam \_\_\_\_\_

Reason for having the exam \_\_\_\_\_

\_\_\_\_\_

Any history of cancer? \_\_\_\_\_

\_\_\_\_\_

Any previous exams or any related exams? \_\_\_\_\_

\_\_\_\_\_

Any surgery or therapy in the past? \_\_\_\_\_

\_\_\_\_\_

Medications: \_\_\_\_\_

\_\_\_\_\_

Notes: (Physical exams, findings, etc.)

\_\_\_\_\_  
 Yes    No   Any possibility of pregnancy?

Yes    No   Are you nursing?

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date